Statement of
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before the

Commerce Committee
Subcommittee on Health and Environment
United States House of Representatives

on

Medicaid Reform

on behalf of

The National Governors' Association

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It is an honor to testify before the committee today on one of the most important issues facing states - the future of the Medicaid program. Today we appear before you as members of the National Governors' Association Medicaid Task Force. Also on the task force are Governor George V. Voinovich of Ohio, Governor Lawton Chiles of Florida, Governor Howard Dean, M.D., of Vermont, and Governor Tommy G. Thompson of Wisconsin.

The Governors' Medicaid Task Force serves as a bipartisan forum for discussion related to the impact of proposed Medicaid policy changes on states. The task force also proactively makes recommendations on program improvements to help states in their efforts to make high-quality, cost-effective health care available to Medicaid recipients.

We welcome the opportunity to share with you our ideas and concerns regarding Medicaid reform. Reform can be effective only when federal and state governments cooperate fully as partners, with joint responsibility for the program.

Briefly, today we will review several issues of primary concern to Governors, including Medicaid cost saving strategies, children's health, and managed care quality.

Much of the discussion about Medicaid reform that has taken place in recent months has focused on producing savings to contribute to efforts to balance the federal budget. No one recognizes more clearly than Governors the need to control Medicaid spending, because we continuously wrestle with the pressure Medicaid exerts on our own budgets. In fact, almost all states must cope with Medicaid costs in the context of state balanced budget requirements.

The challenges Medicaid poses to state budgets became particularly acute in the late 1980s and early 1990s. During that time, Medicaid spending increased at average annual rates in excess of 20 percent. The program grew in both absolute and relative terms, and as a result of this growth, Medicaid now is the second largest expenditure in state budgets, behind primary and secondary education.

These growth rates were unsustainable. Medicaid costs were making it difficult to fund investments in other important state priorities. To address financial pressures and to develop a more quality-oriented system, Governors have begun a massive transformation of state Medicaid systems. Historically, Medicaid programs have been claims processors and bill payers. The transformation currently underway is helping states to become more sophisticated value purchasers of quality health care services and to develop integrated systems of care for vulnerable populations.

Already this transformation is producing results. Medicaid spending grew only 4.5 percent between federal fiscal years 1995 and 1996, and only 3.3 percent between 1996 and 1997. The dramatic reduction in Medicaid growth rates we have enjoyed in recent years stems in large part from aggressive state pursuit of administrative simplification, innovation, and good management.

Our successes in controlling growth rates have been recognized. In February 1997, the Congressional Budget Office (CBO) lowered its baseline projections of future growth in Medicaid spending by almost $86 billion. This recalculation follows a similar baseline revision released in December 1995 that produced $31 billion in Medicaid savings. These reductions could not have been achieved without state cost-containment strategies.

The Governors are committed to building on their record of success in controlling Medicaid costs. But this must be done very carefully. And it must be done in a way that preserves the partnership of shared financial responsibility between the federal government and the states.

Recommended Savings Level

As a starting point for Medicaid reform, we believe it is critically important that the level of Medicaid savings not be set arbitrarily to fill a hole in a deficit reduction package. Instead, Governors, Congress, and the administration should agree on a package of needed Medicaid reforms. The reforms set forth will lead to a level of savings that states and the federal government will be able to achieve by taking advantage of newly expanded programmatic flexibilities. Sound policy should drive Medicaid reform decisions, not budgetary politics.

Any consideration of Medicaid's role in balancing the budget must acknowledge that even before the first decision is made regarding a reconciliation package during this Congress, Medicaid already has contributed $86 billion toward deficit reduction in this budget cycle. CBO's revised baseline projections make efforts to reach a balanced budget agreement easier by $86 billion.

The revised CBO projections reflect the transformations underway in Medicaid programs to become streamlined value-purchasers of quality health care services. Given the progress already made, there is less room in the program from which to squeeze additional savings without having a detrimental effect on the number of people served by Medicaid or the range of benefits they receive.

For that reason, the Governors believe that additional Medicaid savings included in any deficit reduction package developed by Congress and the administration should be kept to a minimum. However, we agree that additional savings are possible, and we are committed to working with you to continue to eliminate all unnecessary spending from the Medicaid program.

We are confident that with the additional flexibility we will ask you for today, states will be able to produce an additional $8 billion in scorable Medicaid savings between now and 2002, very close to the net Medicaid savings included in the President's budget. As has been the case in the past, although the scorable savings may be in the range of $8 billion, our ability to actually achieve savings could exceed CBO's expectations given this enhanced flexibility. Combined with the $86 billion in savings already acknowledged by CBO, Medicaid's contribution to deficit reduction will be at least $94 billion through 2002.

This level of savings should be considered in the context of the Medicaid savings targeted in last year's Medicaid reform efforts. The original Republican reform package would have produced $185 billion in savings by 2002. By the end of the debate, Congress supported a package including Medicaid savings of $85 billion. Throughout last year's reform discussions, the President supported a reform package that would have generated $54 billion in savings.

A $94 billion contribution to deficit reduction by 2002 fits well within these parameters. In fact, when you combine Governors' recommended savings with the two baseline recalculations made by CBO within the last 18 months, Medicaid savings have already contributed $125 billion in deficit reduction, exceeding the targets set forth by Congress and the administration at the end of last year's Medicaid debate.

The Governors therefore would not support the President's proposal to produce $22 billion in gross Medicaid savings by 2002, nor would we support packages calling for even higher levels of Medicaid savings we have heard discussed by many in Congress. As we have said before, savings of that magnitude cannot be achieved without adversely affecting those who rely on Medicaid for their health care needs.

Recommended Savings Strategy

With an expectation of additional achievable savings in the range of $8 billion to add to the $86 billion in savings already realized, the question of primary importance becomes what policy choices will be needed to achieve these savings.

The Governors adamantly oppose a cap on federal Medicaid spending in any form. Any unilateral cap on the Medicaid program will shift costs to state and local governments that they simply cannot afford. Once the federal spending obligation is fulfilled, all additional costs will be passed on to the states. The proposed per capita caps will help the federal government balance the budget on the backs of the states.

The Governors' opposition to Medicaid caps extends to the per capita cap proposals set forth both in the President's budget package and in the budget developed by the Blue Dog Coalition. We oppose these per capita caps for a number of reasons.

First, the caps are unworkable. There would need to be four separate caps on different eligibility categories for each of the fifty states. This means 200 separate caps, which would have to be monitored by state agencies and audited and enforced by a new bureaucracy in the Health Care Financing Administration (HCFA).

Second, caps could result in states becoming solely responsible for unexpected program costs, such as a loss in a lawsuit on reimbursement rates or the development of expensive new therapies that drive up treatment costs beyond the federally allowable rate.

Third, the cost shift resulting from a unilateral federal cap would present states with a number of bad alternatives. States essentially would have to choose between cutting back on payment rates to providers, eliminating optional benefits provided to recipients, ending coverage for optional beneficiaries, or coming up with additional state funds to absorb 100 percent of the cost of services.

It seems unnecessary to us to undertake such a disruptive and fundamental transformation of a program on which the federal government will spend half a trillion dollars over the next five years in order to achieve the $8 billion in additional savings we consider reasonable. If we consider the President's budget package, his expectations for savings attributable to a per capita cap are even smaller. Although his package includes $22 billion in gross Medicaid savings, only $7 billion of that total comes from the program cap.

The President's package also includes $15 billion in savings from the disproportionate share hospital (DSH) program. Because Governors consider $8 billion to be a reasonable savings target, we oppose the magnitude of the DSH cuts included in the President's budget. We also strongly believe that DSH funds must continue to be distributed through states, not directly to providers, to ensure that the program effectively complements other federal and state sources of health care funding. Maintaining the state role in distribution will ensure that DSH is coordinated with the state's overall health systems' infrastructure.

The Governors are convinced that there are better ways to achieve an additional $8 billion in Medicaid savings by 2002, and NGA's Medicaid Task Force has developed an alternative. Our strategy sets forth a number of policy options that, when combined, will produce significant savings. We believe those savings will be scorable at $8 billion through 2002, and upon implementation will likely yield additional savings. The savings in our alternative strategy stem from a series of policy changes that would assist states in their continued transformation toward value purchasing.

In some combination, the reform suggestions we believe Congress and the administration should consider would eliminate the need to institute any unilateral cap on beneficiary spending. We can group these suggested reforms into three broad categories – reforms related to managed care, reforms tied to reimbursement policy, and other program reforms.

Managed care reforms

1. *Managed care*. Repeal of the waiver requirement for mandatory managed care will facilitate further development of the Medicaid managed care market. As Medicaid markets mature, competition between managed care entities will enable states to negotiate even more favorable rates. With the development of models to accommodate special population needs, Medicaid managed care will increasingly penetrate the more complicated and costly segments of the caseload -- the elderly and disabled.

States have already achieved significant savings through Medicaid managed care. For example, Michigan will save $120 million in Medicaid costs through managed care in 1998, about 2.5 percent of the state's total program budget. Missouri's managed care program will have saved $50 million through 1997 compared to fee for service costs.

Managed care does not simply produce a one-time savings bonus for states. Between 1990 and 1996, Wisconsin has saved more than $100 million as a result of managed care. Through competitive bidding, Florida's newest round of managed care contracts include capitation rates between 87 percent and 92 percent of fee for service rates. Previous contracts included rates at 95 percent of fee for service rates.

2. *Managed care for the dually eligible*. The dually eligible population, which currently is 6 million people, would be enrolled in managed care, creating a more streamlined, cost-effective system of health care delivery for those elderly and disabled individuals who receive a complete, but uncoordinated, package of benefits from both Medicaid and Medicare. Managed care would produce savings for both programs while creating a more user-friendly health care experience for recipients.

Utah has conducted a voluntary managed care program for the dually eligible, operating within existing federal limitations, and has seen a reduction in costs for services of approximately 10 percent for the population enrolled in managed care. Minnesota's managed care program for the dually eligible has produced a 5 percent reduction compared with fee for service costs.

We would like to submit for the record an NGA staff working paper that begins to explore issues related to the connections between the Medicaid and Medicare programs, including dual eligibility, and the implications of those connections for the states.

3. *Provider selectivity*. To clarify that there is no *de facto* entitlement for providers to participate in the Medicaid program in the fee for service environment, HCFA should support states in their efforts to contract

with a limited number of facilities so they can negotiate better rates. For example, Medicaid recipients could be directed to two out of four hospitals in a city for services, or to a particular source to have prescriptions filled. Texas and Washington each have achieved 2 percent savings in their hospital reimbursement rates through selective contracting.

Reimbursement policy reforms

4. Reimbursement rates for Qualified Medicare Beneficiaries (QMBs) and the dually eligible. Recent judicial interpretations have begun to force states to reimburse providers at Medicare rates for services provided to these populations. Medicaid rates, which are on average significantly lower than Medicare rates, should be sufficient to discharge state obligations until the federal government assumes full responsibility for the cost-sharing obligations associated with QMBs and until a more integrated system is developed to serve the dually eligible.

Michigan estimates that permitting the state to limit reimbursement rates to Medicaid levels for these populations would save $85 million per year in Michigan alone. Florida had to include $87 million in its 1997-1998 budget following a suit requiring the state to use Medicare rather than Medicaid reimbursement rates. Alabama has seen its costs increase approximately $50 million per year following its loss in the defining case on this issue, *Haynes Ambulance Service, Inc., et al. v. State of Alabama, et al*.

5. Boren repeal. The states and HCFA agree that reimbursement rates for institutional care will be significantly moderated when the Boren amendment is repealed. The American Public Welfare Association has developed a model projecting federal savings through Boren repeal ranging from a conservative estimate of $6 billion to as much as $8 billion over four years in nursing facility costs and additional savings ranging from a low of $4 billion to $10 billion in hospital costs. The Governors would welcome the opportunity to work with Congress and the Administration to fully explore the cost saving potential of repealing the Boren Amendment.

6. *Cost based reimbursement*. Policies that require states to reimburse providers such as federally qualified health clinics (FQHCs) at rates that do not reflect states' positions as dominant purchasers in the health care marketplace should be repealed. Wisconsin will save $5 million annually through the repeal of FQHC provider protections.

Similarly, Boren-like language that has exposed states to lawsuits driving up rates for services including outpatient and home health care should be repealed. California's recent loss of a case on outpatient care rates will cost the state hundreds of millions per year. Ohio currently faces a cost-based reimbursement lawsuit for home health services that could cost the state between $100 million and $130 million, essentially doubling home health reimbursement rates.

Other reforms

7. Cost sharing. Significant Medicaid savings could be realized through a number of cost sharing models. For example, if every Medicaid recipient were responsible for a sliding scale premium that averages $5 monthly, more than $2 billion in Medicaid savings would be generated annually, contributing significantly to efforts to avoid a per capita cap in spending. An even more fundamental reexamination of family cost-sharing obligations for children with disabilities living at home or institutions would yield additional savings.

Oregon has implemented a sliding scale premium for new enrollees in the Oregon Health Plan, with premiums ranging from $6 to $28 per month. Between December 1995 and January 1997, Oregon has collected more than $7 million in premiums from its expanded eligibility group of approximately 75,000 households.

8. *EPSDT*. Governors, Congress and the Administration should work together to assess the difference in cost between EPSDT and an actuarially based package of benefits comparable to those offered by Medicaid's package of mandatory and optional benefits.

9. *Fraud and abuse*. Aggressive new state-based strategies to prevent Medicaid fraud should be expanded nationwide as needed. For example, a Florida fraud reduction initiative that includes a provision requiring durable medical equipment suppliers to purchase surety bonds has produced savings between 1 percent and 2 percent of the state's total Medicaid budget. Florida's nonpartisan budget scoring entity predicts additional savings from fraud reduction of $81 million in 1998 and $111 million in 1999.

We would like to submit for the record a more detailed listing of these proposals, including the specific legislative barriers that currently prevent implementation.

Some of these options were included in President Clinton's budget package, and the Governors gratefully acknowledge the President's support of important state flexibility priorities, including elimination of the need for 1915(B) waivers to enroll recipients in managed care; elimination of the need for waivers to provide recipients with home- and community-based supports as alternatives to institutional care; repeal of the Boren Amendment; repeal of the 75-25 rule; and repeal of the cost-based reimbursement requirement for FQHCs. When considered separately from the per capita cap, we are confident that CBO will recognize the savings potential of these recommended reforms.

The Governors would welcome the opportunity to work with Congress and the administration to further explore any of the recommendations we have set forth regarding cost savings. We also would be happy to provide you with any additional information you may require.

Although program financing and cost savings have dominated the Medicaid reform discussion so far this year, the Governors are also very interested in other reform initiatives that could impact the Medicaid program. We expect that issues related to children's health and managed care quality will also be at the top of congressional priority lists during the next few months, and we would like to briefly share with you some of our ideas concerning these important topics.

Children's Health

Like Congress and the administration, the Governors agree that health care is essential to the well-being of children. In fact, states have been leaders in making insurance coverage available to millions of children. There are 18.7 million children below age eighteen who are covered today by Medicaid. Thirty-nine states already have extended Medicaid eligibility beyond federally mandated levels.

Other states are in the process of implementing major expansions for children's coverage. In recent weeks, Governor David M. Beasley of South Carolina has announced a Medicaid expansion that will extend coverage to 50,000 children. Governor George V. Voinovich of Ohio has included in his budget a plan to cover 96,000 additional kids. Arizona, Arkansas, Florida, Massachusetts, New Jersey, North Carolina, Utah, and Wisconsin also plan eligibility expansions for children. Medicaid savings levels in the range of

those included in the President's budget, the Blue Dog Coalition plan, and the even higher levels discussed by others in Congress will jeopardize these and other state expansions of Medicaid eligibility.

States are also experimenting with approaches outside of the traditional Medicaid framework to extend health care coverage to more children. For example, Florida's Healthy Kids program seeks to give children access to health care through a school enrollment-based program. Governor Lawton Chiles plans to extend the Healthy Kids program to an additional 60,000 children this year. New York's Child Health Insurance Program makes health coverage available to children below age nineteen who would not otherwise have access to health insurance. These experiments, and others underway in Minnesota and Pennsylvania, typically rely on state funds and family contributions.

We understand that during the next few months, Congress and the administration will likely consider a number of different approaches to extending health insurance coverage to children who are currently uninsured. The Governors are in the process of reviewing the various children's health proposals that have been set forth thus far. We can share with you some preliminary thoughts.

First, we believe it is critical that any new federal initiative be designed to complement, not jeopardize, the array of children's health activities underway in the states.

Second, new programs should not create an opportunity for shifting private sector insurance costs to the public sector.

Third, the Governors would oppose any mandated Medicaid eligibility expansion.

The Governors are particularly interested in issues surrounding the population of children currently eligible for Medicaid but not enrolled in the program. We understand that the General Accounting Office (GAO) estimates that 2.9 million children fall into this category.

We would appreciate any assistance GAO could provide in helping states learn more about this population. The Governors strongly agree that children entitled to Medicaid benefits should receive those benefits. In order to make that happen, we need to know more specifically who is not receiving coverage, where they live, and how old they are.

The Governors are ready to do more where more is needed, but we must keep in mind that the process of successfully enrolling this group of children in Medicaid is more difficult than it may appear initially for a number of reasons. First, some of these children may not need Medicaid. They may already have health insurance coverage through a noncustodial parent. Second, states like Vermont with extensive experience in children's health issues have found that some families avoid association with Medicaid because of a perceived stigma. Finally, as Medicaid will be instantly available to these children should a need arise, their families may not feel compelled to enroll before they encounter a particular need for services.

States already have in place a broad array of outreach strategies designed to promote Medicaid enrollment. Those strategies include simplifying eligibility processes, promoting aggressive public awareness campaigns, locating enrollment centers out in communities, and using a single application form for a number of assistance programs, just to name a few examples of effective outreach programs. We would like to submit for the record an initial compilation of state outreach activities prepared by the National Governors' Association.

If we had a more concrete sense of who is *not* being captured by existing outreach efforts, more targeted strategies could be put in place. For example, an outreach campaign targeted at school-age children would be designed differently than one aimed at infants and toddlers.

Managed Care and Quality

Given their history of leadership on this issue, the Governors also have been following with interest the emerging debate surrounding quality in the Medicaid managed care environment. Through their contracting practices, Medicaid programs already prioritize quality protections, and managed care has been an effective means of delivering quality health care services in the states. In some states, Medicaid managed care has been the most effective means of delivering quality health care to recipients. Like you, we are committed to ensuring that all Medicaid recipients receive high-quality health care.

The Governors believe that this goal can be accomplished most effectively through a broad-based agenda focused on monitoring quality and evaluating improvement, rather than through a series of procedure-specific requirements. This approach builds in the flexibility to address medical innovations and to take advantage of the continuous evolution of more sensitive and sophisticated quality measures.

NGA's Medicaid Task Force has begun preliminary discussions about what would be included in a quality package, and the Health Care Financing Administration has expressed strong interest in the approach we are developing.

As envisioned by the NGA Medicaid Task Force, states would develop quality assurance plans, which could include a number of elements, such as a grievance process, a comparative report card of health plan performance, deeming of NCQA accreditation standards, and HEDIS reporting requirements. States could establish benchmarks tied to measuring future quality performance. A number of indicators could be monitored and assessed annually by states, including consumer satisfaction, immunization rates, and numbers of low-birthweight babies, to name just a few from dozens of possibilities.

These plans would be submitted to HCFA, and updates would be provided annually. The states would monitor the results achieved by health plans in meeting the goals established for them, and this performance would be considered by the state when deciding whether to continue the contractual relationship between the health plan and the Medicaid program.

Quality monitoring would continue to be an important part of a state's role as a value purchaser of health care services. A critical component of efforts to promote quality would involve the development of a more informed consumer base. Our goal would be to help Medicaid recipients make good choices for themselves while creating mechanisms to ensure that problems get resolved quickly and successfully.

We would welcome the opportunity to work with Congress as managed care quality issues are debated. We are hopeful that the quality assurance partnership we envision between the states, managed care organizations, and consumers could become a model worthy of replication.

We thank you for your interest in the Governors' perspective on Medicaid reform. As the reform process moves forward, this committee will consider a range of issues of the utmost importance to states. Please view us as a resource. We will be happy to provide you with additional information on any of the issues

outlined in our testimony. We appreciate your consideration of our ideas and concerns, and we would be happy to answer any questions you may have.